PATIENT CENTERED MEDICAL HOMES

Maryland's Patient Centered Medical Home Program

Overview of the Program

Ben Steffen

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MHCC | MARYLAND HEALTH CARE COMMISSION

MARYLAND

The Challenge

- Health care reform is counting on a robust primary care sector to improve quality, reduce costs, and improve patient experience.
- "The Patient Protection and Affordable Care Act (PPACA) of 2010 brings both promise and peril for primary care. This Act has the potential to reestablish primary care as the foundation of US health care delivery."[1]
- … yet primary care appears to be dispirited, provides mediocre quality, and is rapidly diminishing in size. "The peril is that the ACA initiatives may not alter the current trend toward an increasingly specialized physician workforce."[2]
  - Dispirited -- changing demography and practice content, increasing demand, greater care complexity, declining real income, need to work harder and harder. " . . . many students [don't pursue] residency training in a primary care specialty because they are concerned that they will not be adequately prepared to meet the responsibilities of such a practice."[3]
  - Diminishing -- percentage of medical students choosing primary care specialties (FP, Peds, IM) fell from about 40 percent in 1999 to 25 percent in 2009.

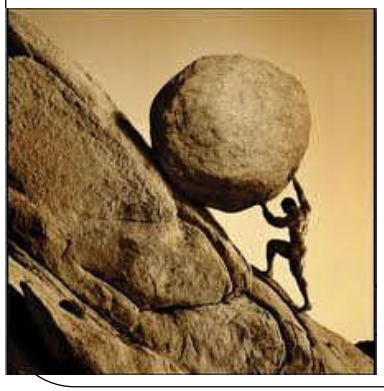
[1,2] Goodson Journal Annals Internal Medicine. 2010; 152:742

[3] Whitcomb ME, Cohen JJ. New Engl Journal of Medicine. 2004;351(7):710–12.

What Keeps Providers So Busy in Primary Care?

On average:

- 17 e-mail messages to write,
- 14 consultation reports to review,
- 24 phone calls to field,
- 11 X-ray and imaging reports to read,
- 12 prescriptions to refill (not including those done during a visit or phone call)
- 20 laboratory reports to be checked,
- On top of the work of seeing more than 18 patients/day



Source: “What‘s Keeping Us So Busy in Primary Care?” Richard J. Baron, M.D., New Engl. J Med 2010; 362:1632---1636 April 29,

Primary Care's Decline: Does it Matter?

- "The declining interest in careers in primary care is important because the collapse of primary care will result in higher health care expenses and lower health care quality."[1]

- 95% of individuals report that is important that they "have one practice/clinic where doctors and nurses know you, provide and coordinate the care that you need."

- Countries with better primary care have better health outcomes and lower costs.

- States with higher primary care/population ratios have lower costs and better quality.

- Primary care is worth saving, but new models are needed.

[1] How Is a Shortage Of Primary Care Physicians Affecting The Quality And Cost Of Medical Care? A Comprehensive Review, The American College Of Physicians, April 2008

Introducing the Maryland Multi-Payer Program

- **Convener:** Maryland Quality and Cost Council
- **Legislation:** Administration-sponsored legislation passed in 2010 established the multi-payer program and provided an exemption for a cost-based incentive payment.
- **Governance:** MHCC with advice from representatives from provider groups, health plans, purchasers, state agencies, and community organizations.
- **Project management and funding:** MHCC provides dedicated project management and has dedicated funds to support the evaluation of the program.
- **Participating practices:** 52 pilot sites started in May 2011. Practices includes 2 federally qualified health centers, an academically affiliated family medicine practice, hospital-owned medical practices, two internal medicine practices, family medicine practices, 3 independent family medicine physicians, and 2 independent internal medicine physicians
- **Practice Transformation**: PCMH implementation for the 52 practices is supported through the Maryland Learning Collaborative, a venture funded by the Maryland Community Health Resources Commission and led by clinicians from the School of Medicine at Maryland and Johns Hopkins Community Physicians.

Introducing the Maryland Multi-Payer Program (MMPP)…

- **Providers:** 330 providers, including physicians and nurse practitioners, will participate in the program. Approximately 40 residents will benefit from the program.
- **Key Public Plan Sponsors:** Maryland State Employee Health Plan, Maryland Health Insurance Program, Federal Employee Health Benefit Program, and TRICARE.
- **Payment model:** Practices receive a fixed transformation payment for each attributed patient in addition to standard fee for service payments. The fixed transformation payment covers the cost of care management and other features of the PCMH model. Practices receive a share of savings that result from the program.
- **Quality Improvements:** Practices report up to 21 quality measures in year 1. In years 2 and 3 of the program, it is anticipated that practices will show improvements in the quality measures and reductions in ER visits and patient hospital days per 1,000 patients

Introducing the Maryland Multi-Payer Program (MMPP)…

- **Unique Features:**
  - The MMPP is one of the first PCMH programs to have 100% large carrier participation and to implement a shared savings requirement.
  - Collaboration of Maryland's leading medical institutions in fostering practice transformation is the first of its kind in PCMH programs.
  - One of the first PCMH programs with a defined shared savings payment approach.
  - Formal evaluation funded by the MHCC. The MMPP participates in a common evaluation and best practices collaborative with leading PCMH states convened by Milbank.

Funding and Supporting Partners

- **Department of Health and Mental Hygiene**
  - ✓ Medicaid
  - ✓ Community Health Resources Commission – Funder of the Maryland Learning Collaborative

- **Commercial Carriers – Aetna, CareFirst, CIGNA, Coventry, United HealthCare, and Maryland MCOs**
- **Plan Sponsors**
  - ✓ State of Maryland Employee Health Plan
  - ✓ Federal Employee Health Benefits Program
  - ✓ Maryland Health Insurance Program

- **Maryland Learning Collaborative- Practice Transformation**
  - ✓ Dept of Family and Community Medicine & School of Nursing at University of MD
  - ✓ Johns Hopkins Community Physicians and Guided Care at Johns Hopkins
  - ✓ Kaiser Permanente

- **Health IT Adoption - CRISPHEALTH**

- **Outreach**
  - ✓ Mid-Atlantic Business Group on Health
  - ✓ Merck & Co., Inc.
  - ✓ Pfizer Inc.
  - ✓ Sanofi-aventis
  - ✓ Benefit consultants (AON, Carl Walker Associates, CBIZ, Hays, Mercer, and others)

- **Consultants**
  - ✓ Remedy Health Care Consulting – Practice Transformation
  - ✓ NCQA – Recognition
  - ✓ Discern Consulting LLC – Payment Development
  - ✓ Social and Scientific Systems – Data Aggregation and Attribution
  - ✓ Evaluation Consultant - TBD

What do we want to accomplish?

- Engage a geographically diverse group of practices -- large and small private practices, hospital-owned practices, and community clinics.
- Train 300 clinicians
- Activate 300,000 patients
- Demonstrate that practices at varying levels of sophistication and serving diverse patient populations can improve quality, lower costs, and increase clinicians' joy in work and patient satisfaction
- Confirm the feasibility of diffusion of the model using a sound evaluation approach.

MMPP is faithful to PCMH concepts

- **Key principles of primary care:**
- Accessible (first contact care) - point of entry for each new problem;
- Continuous – ongoing care over time;
- Comprehensive – provides or arranges for services across all of patient's health care needs;
- Coordinated – integration of care across a person's conditions, providers, and settings, and with the patient's family, caregivers, and community.
- Other primary care principles
- Improvements through a systems-based approach to quality and safety
- Patient-centered – needs and wishes of patient and family are consciously considered.

- **PCMH practices will place special emphasis on developing the chronic care and preventive care processes that can improve the health of the practice's entire population.**

What will the patient receive?

1. 24-7 phone communication with a clinician for urgent needs.
2. Convenient appointments – due to open access scheduling.
3. Shorter waiting times.
4. Email and telephone consultations.
5. Care management and coordination by specially trained team members:
   - ✓ Treatment plans;
   - ✓ Preventive and follow-up care;
   - ✓ Reminders for medical appointments; and
   - ✓ Assistance with self care.
6. Medication reconciliation every visit:
   - ✓ Reviewing medication for drug interactions, allergies, and lower cost alternatives.
7. E-prescribing.*
8. Pre-visit outreach and after-visit follow-up by a care manager.
9. Medical record access.*

∗ ***These features of a Maryland PCMH practice are not a requirement until the end of Year 2.***

Payment reform requires more than one method, you have dials, adjust them

"fee for health"

"fee for outcome"

"fee for process"

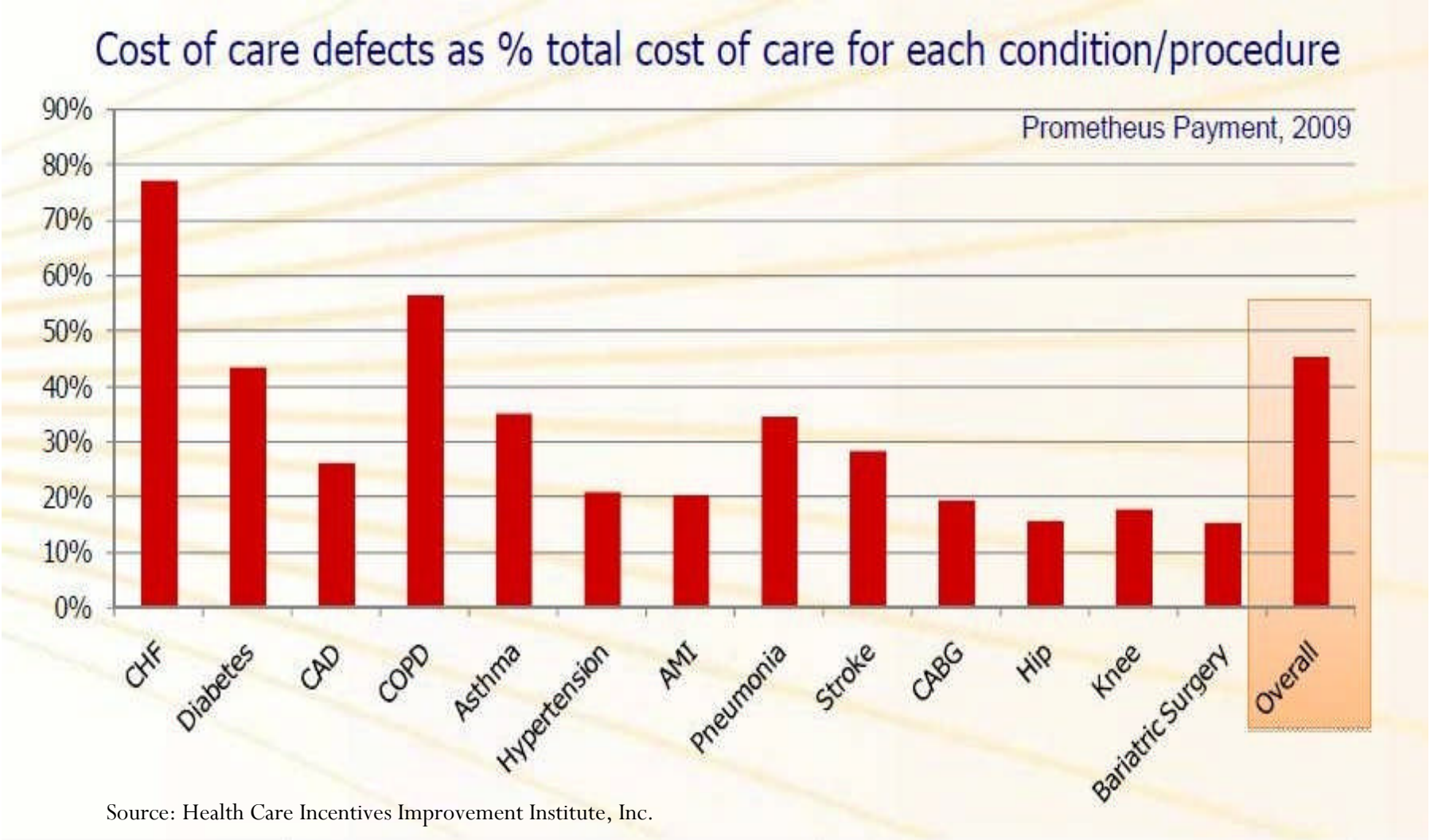
"fee for belonging"

"fee for service"

"fee for satisfaction"

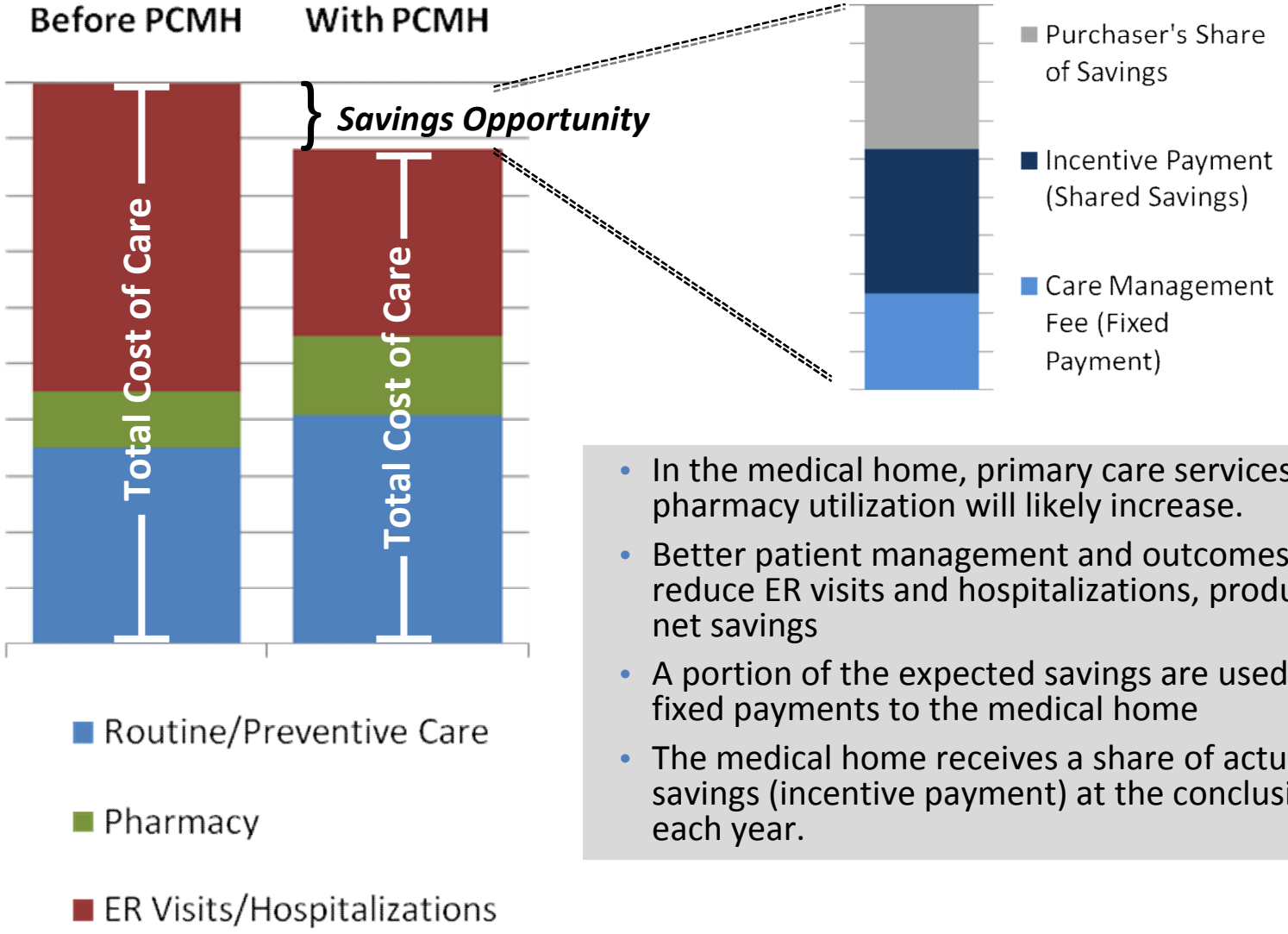
Source: Paul Grundy, MD MPH, IBM, Presentation delivered March 30, 2011, Rockville, MD

Gaps in Care Increase Costs



Source: Health Care Incentives Improvement Institute, Inc.

How will savings be achieved?



- In the medical home, primary care services and pharmacy utilization will likely increase.
- Better patient management and outcomes will reduce ER visits and hospitalizations, producing net savings
- A portion of the expected savings are used to fund fixed payments to the medical home
- The medical home receives a share of actual savings (incentive payment) at the conclusion of each year.

The "Dials?"

Fee-For-Service

Primary care practices will continue to be reimbursed under their existing fee-for-service payment arrangements with health plans.

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Fixed Transformation Payment (investment)

Primary care practices will receive a fixed, per patient per month fee (paid semi-annually). The purpose of this fee is to defray the costs of providing enhanced primary care services, including care coordination.

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Incentive Payment (Shared Savings must be earned)

Primary care practices will receive a share of any savings generated by improved patient outcomes. Savings calculations will be performed using the MHCC's all-payer claims database.

Roadmap for Practices -- Transform the way in which they deliver care

- Designate a Practice Champion and an Internal Coach
- Participate in a learning collaborative convened by organized medicine and seasoned practice transformation experts.
- Deliver team-based care and begin to operate as a PCMH
- Achieve NCQA Recognition as a PCMH
- Measure and report on quality and performance
- Continue on the path of improvement

Prospects for Expansion

- Growing momentum from practices, payers, and purchasers.

- The modern PCMH is still a very young model, only now beginning to be implemented in real world practices, and with almost no published high quality evaluations… AHRQ, March 2011

- MMPP program will report evidence to Governor and Maryland General Assembly in 2014. Prospects for expanding the program exist, if early results are promising.
  - Improvements in quality
  - Cost savings
  - Increased patient satisfaction with care and provider satisfaction with work
  - Reduction in health disparities